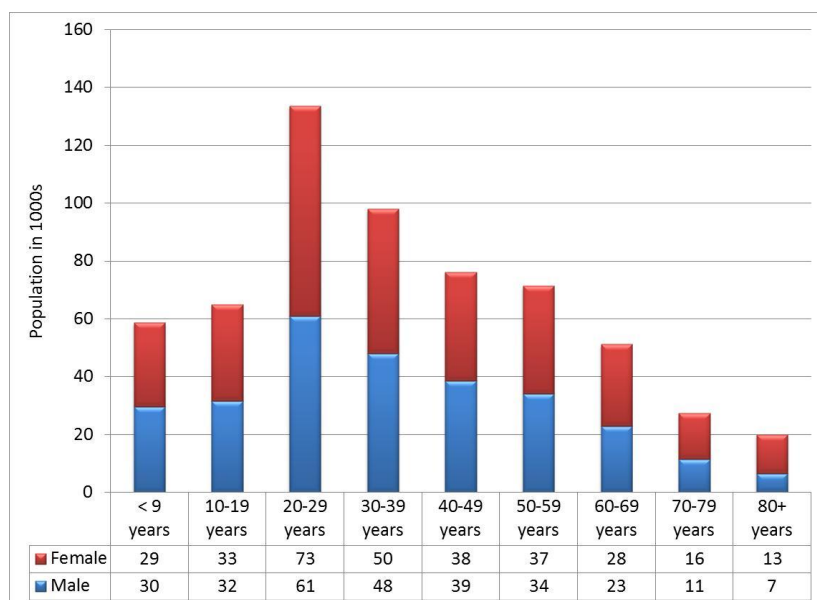


## POLICY ACADEMY

## D.C. Population

D.C. POPULATION (IN 1,000s)—AGE GROUP



Source: U.S. Census Bureau, 2010

D.C. is home to more than 600,000 people. Of these, approximately 170,000 (28.2 percent) are over age 50; nearly 100,000 (16.4 percent) are over 60; nearly 50,000 (7.9 percent) are over 70; and more than 20,000 (3.3 percent) are over 80. The proportion of women rises steadily with each age group—66.9 percent of those 80 and older are women. The racial/ethnic composition of Washingtonians is as follows:

Race/Ethnicity of Washingtonians

Age	White	Black	Am Indian AK Native	Other	White not Hispanic
<55	39.2%	50.6%	0.3%	9.9%	34.0%
55+	34.0%	61.0%	0.3%	4.7%	31.2%

Source: U.S. Census Bureau Projections, 2009

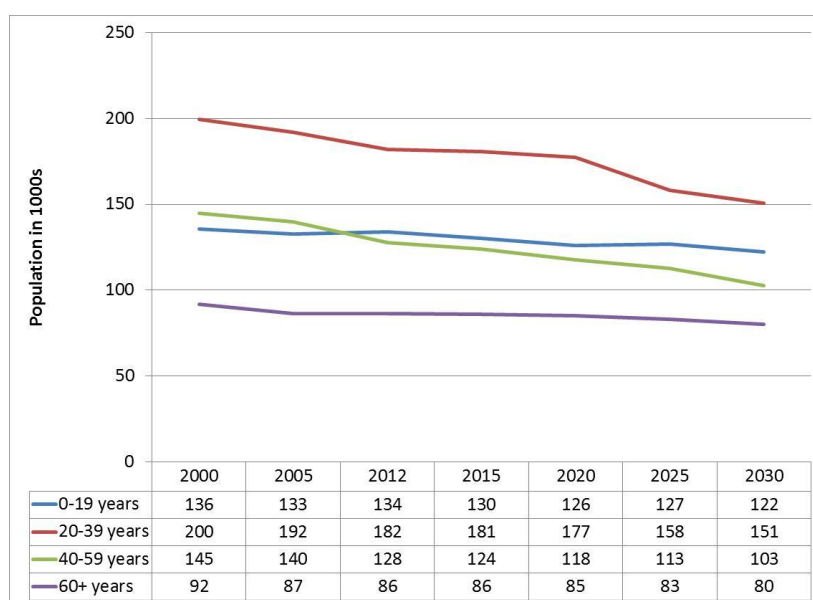
## THE NUMBER OF OLDER WASHINGTONIANS WILL GROW (POPULATION IN 1,000s)

While D.C.'s overall population is projected to decline, the proportion of that population that is 60 and older is projected to grow. The U.S. Census Bureau estimates that, overall, D.C.'s population will decline more than 14 percent from 2012 to 2030; however, the proportion of the population 60 and older will increase by about 8 percent, from 16.3 percent of the total population in 2012 to 17.6 percent in 2030.

Projected D.C. Population

Age Group	2012	2020	2030
0 to 19	25.3%	24.9%	26.8%
20 to 39	34.4%	35.0%	33.1%
40 to 59	24.1%	23.2%	22.5%
60+	16.3%	16.8%	17.6%

Source: U.S. Census Bureau Projections, 2009



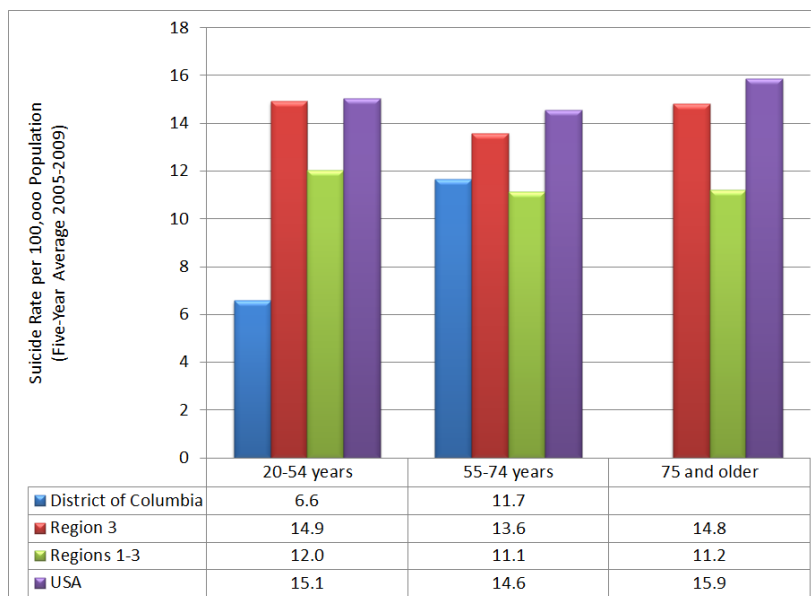
Source: U.S. Census Bureau Projections, 2009

# Suicide Among Older Washingtonians

## 2005–2009 NATIONAL AND REGIONAL SUICIDE RATES PER 100,000 POPULATION

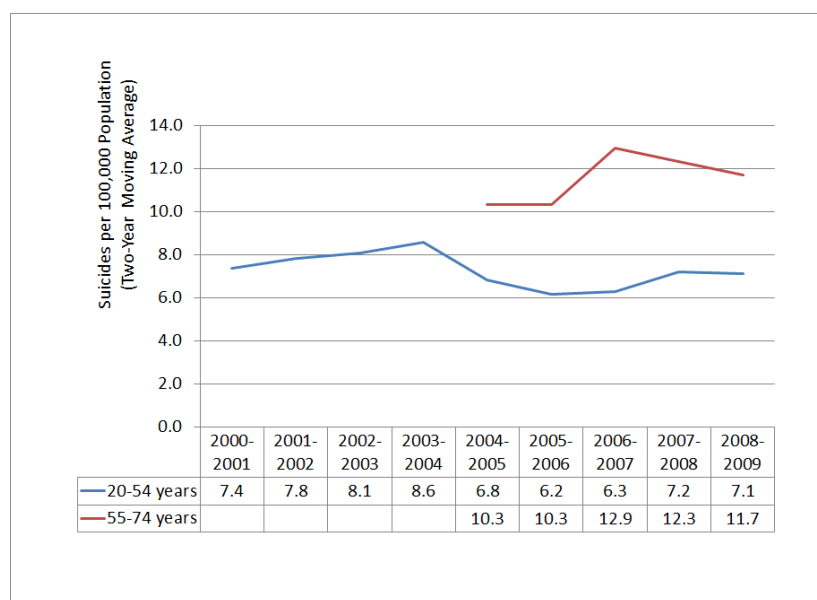
The five-year average suicide rate among Washingtonians ages 55–74 is akin to the national and regional rates. States in the Region 1-3 include Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, U.S. Virgin Islands, Vermont, Virginia, and West Virginia. The five-year average rate is used because the D.C. population is small and a minor change in reported rates can cause large swings in the calculated rate. Figures for the population ages 75 and older were suppressed because of confidentiality concerns. In 2008, the latest year for which comparable national data were available, it is estimated that 18 Washingtonians older than age 55 committed suicide.

States vary in their reporting practices regarding suicide deaths. The apparent rate of suicide is influenced by these reporting practices.



Source: Centers for Disease Control and Prevention (CDC) Vital Statistics, 2009

## D.C. SUICIDE TREND



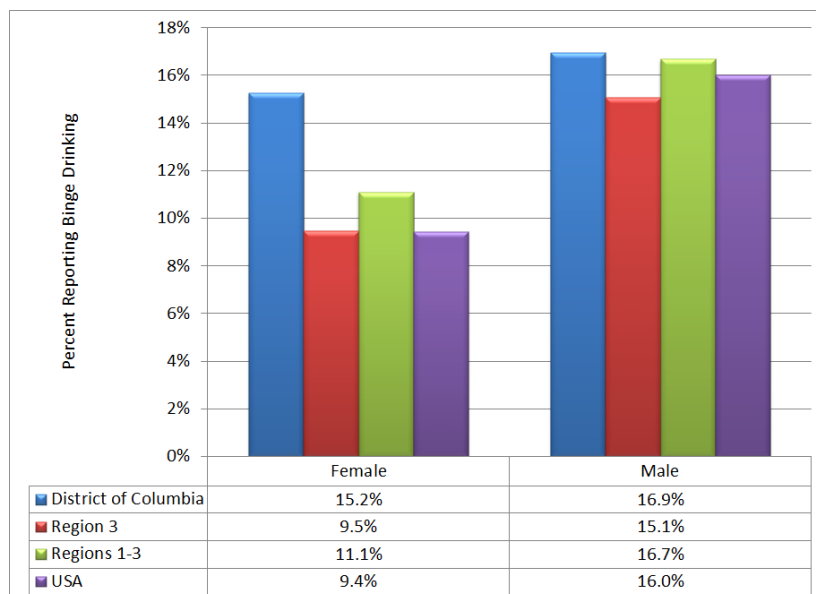
The rate of suicide among Washingtonians ages 55–74 is higher than the rate among the 20–54 age group in the years reported. Two-year average rates among the 55–74 group fluctuated from a high of 12.9 in 2006–2007 to a low of 10.3 in 2004–2005 and 2005–2006. Rates among the 55–74 age group for 2000–2004 and the 75 and older group for all years were suppressed because of confidentiality concerns brought about by low numbers.

Please note: States may vary in their suicide reporting practices and may vary from year to year within the same state. The number of suicides is generally low, so even a small difference in reported numbers may make the rate appear to fluctuate widely.

Source: CDC Vital Statistics, 2009

# Older Washingtonians' Substance Use/Abuse

## 30-DAY BINGE DRINKING AMONG OLDER WASHINGTONIANS—GENDER



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2011

Duke Medicine News (August 17, 2009) notes that binge drinking can cause “serious problems, such as stroke, cardiovascular disease, liver disease, neurological damage and poor diabetes control.” Binge drinkers are more likely to take risks such as driving while intoxicated and to experience falls and other accidents. Older adults have less tolerance for alcohol. Therefore, the figure at left defines a “binge” as three or more drinks for women and four or more for men. As shown, binge drinking is higher among men, but the difference between male and female rates is less pronounced in D.C. than in the region or the nation. Confidence intervals for regional/national and D.C. estimates are less than  $\pm 0.2$  and  $\pm 2.0$  percent, respectively.

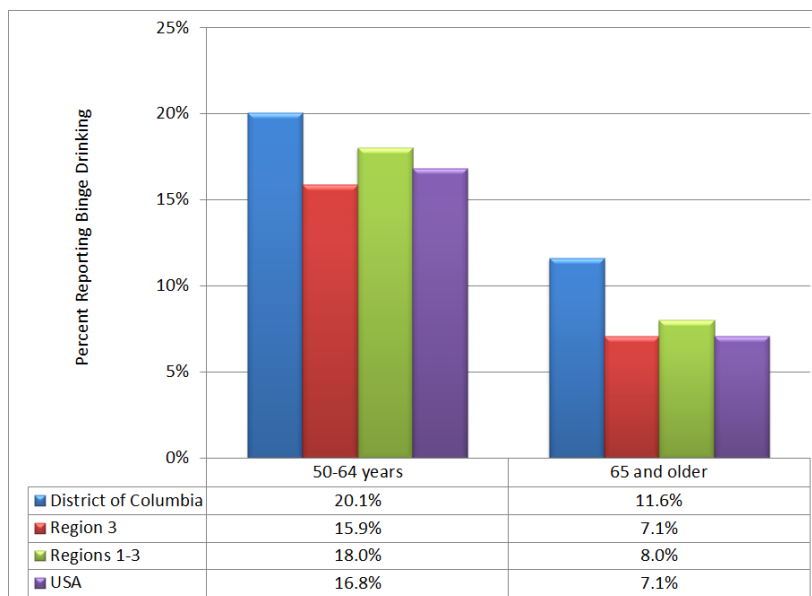
## 30-DAY BINGE DRINKING AMONG OLDER WASHINGTONIANS—AGE GROUP

Binge drinking tends to decrease with age. More than 20 percent of Washingtonians ages 50–64 reported binge drinking, whereas 11.6 percent in the 65 and older group reported similar behavior. Confidence intervals for regional/national and D.C. estimates are less than  $\pm 0.2$  and  $\pm 2.0$  percent, respectively.

The table below provides a breakdown by age group and gender.

### Percentage of Washingtonians Reporting Binge Drinking by Age and Gender

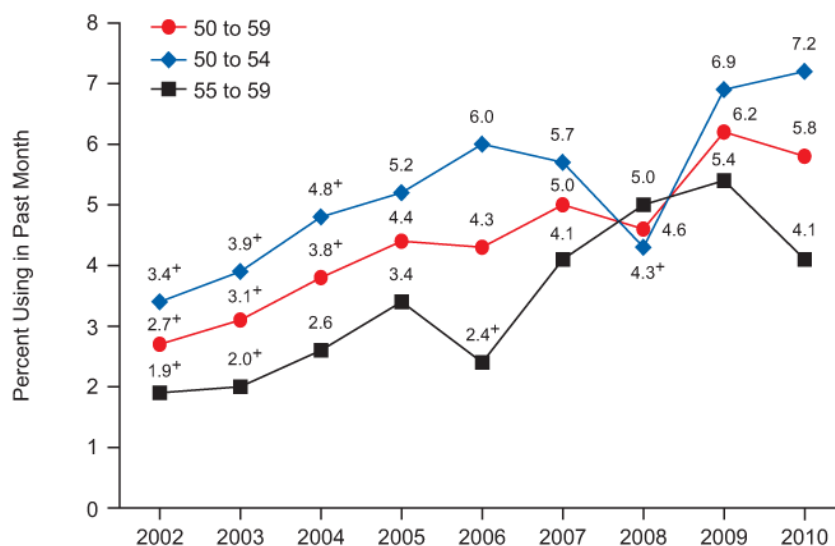
	50-64 years	65 and older
Female	20.0%	10.5%
Male	20.2%	13.3%



Source: BRFSS, 2011

### ILLICIT DRUG USE AMONG OLDER AMERICANS

Nationally, illicit drug use has more than doubled among 50–59-year-olds since 2002. The rate rose from 3.4 to 7.2 percent among 50–54-year-olds and from 1.9 to 4.1 percent among 55–59-year-olds. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “These patterns and trends partially reflect the aging into these age groups of members of the baby boom cohort, whose rates of illicit drug use have been higher than those of older cohorts.” Specific data about substance abuse among older Washingtonians are not available; however, the SAMHSA National Survey on Drug Use and Health (NSDUH) (<http://www.oas.samhsa.gov/2k9/state/Cover.pdf>) provides general information about substance use in the District of Columbia.



Source: NSDUH, 2010

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### DRUG-RELATED EMERGENCY DEPARTMENT VISITS INVOLVING PHARMACEUTICAL MISUSE AND ABUSE BY OLDER ADULTS

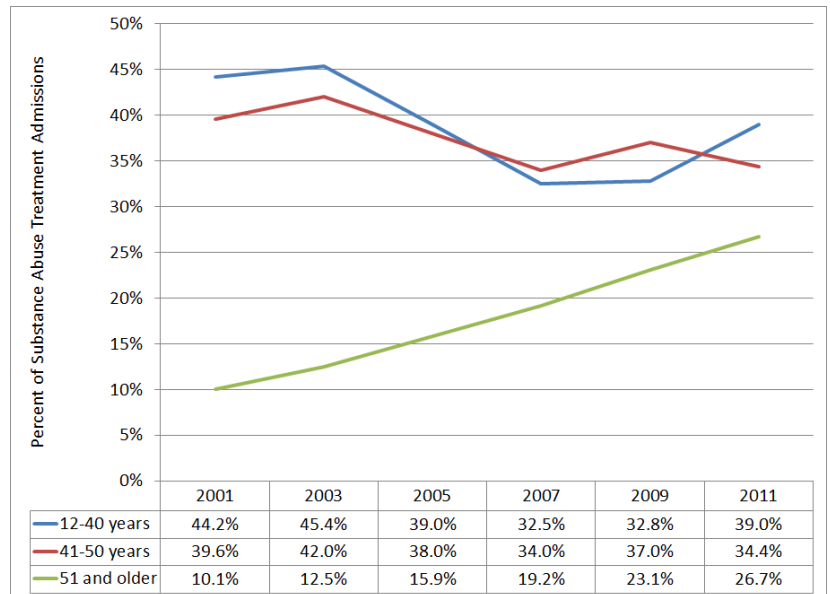
SAMHSA’s Center for Behavioral Health Statistics and Quality periodically releases reports from the Drug Abuse Warning Network (DAWN). DAWN comprises a nationwide network of hospital emergency rooms (ERs) primarily located in large metropolitan areas. DAWN data consist of professional reviews of ER records to determine the likelihood and extent to which alcohol and drug abuse was involved. According to the November 25, 2010, *DAWN Report*:

- In 2004, there were an estimated 115,803 emergency department (ED) visits involving pharmaceutical misuse and abuse by adults aged 50 or older; in 2008, there were 256,097 such visits, representing an increase of 121.1 percent
- One fifth (19.7 percent) of ED visits involving pharmaceutical misuse and abuse among older adults were made by persons aged 70 or older
- Among ED visits made by older adults, pain relievers were the type of pharmaceutical most commonly involved (43.5 percent), followed by drugs used to treat anxiety or insomnia (31.8 percent) and antidepressants (8.6 percent)
- Among patients aged 50 or older who visited the ED for pharmaceutical misuse or abuse, more than half (52.3 percent) were treated and released, and more than one third (37.5 percent) were admitted to the hospital (italic text is taken directly from the report, available at <http://www.samhsa.gov/data/2k10/WebSR018Pharma50+/Pharma50+HTML.pdf>).

## ADMISSIONS TO SUBSTANCE ABUSE TREATMENT AMONG WASHINGTONIANS AGES 51 AND OLDER

Over the past 10 years, the proportion of admissions to public substance abuse treatment programs attributable to adults ages 51 and older has skyrocketed—from 10.1 percent of all admissions in 2001 to 26.7 percent of admissions in 2011. This represents an increase of more than 160 percent. The proportion of admissions represented by the 41–50 and 12–40 groups fell slightly during the same period.

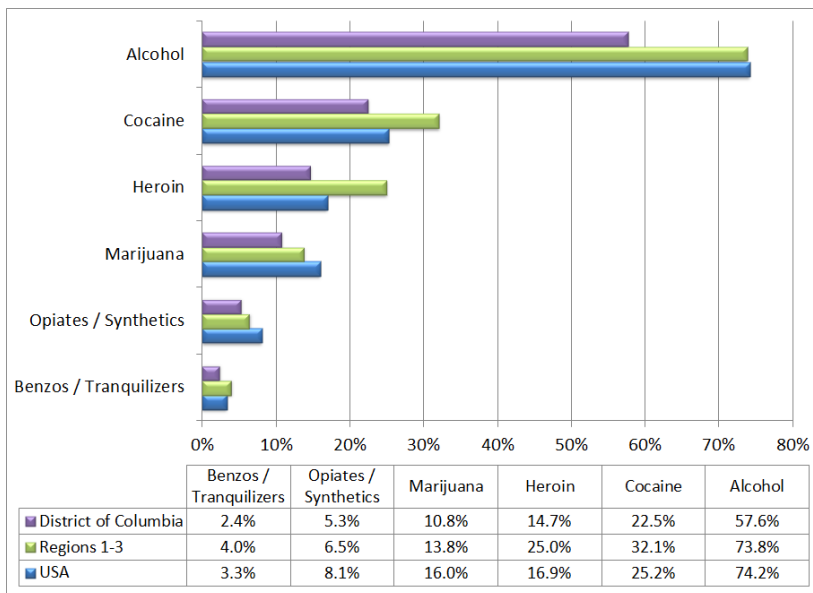
Please note: The District did not report admission data to the Treatment Episode Data Set (TEDS) in 2004–2006 or in 2009. These figures were imputed based on the trends shown in data reported in other years.



Source: TEDS, 2001–2011

Data include only those clients reported to TEDS

## TREATMENT ADMISSIONS AGES 50 AND OLDER—SUBSTANCES USED



Source: TEDS, 2008<sup>1</sup>

Data include only those admissions reported to TEDS

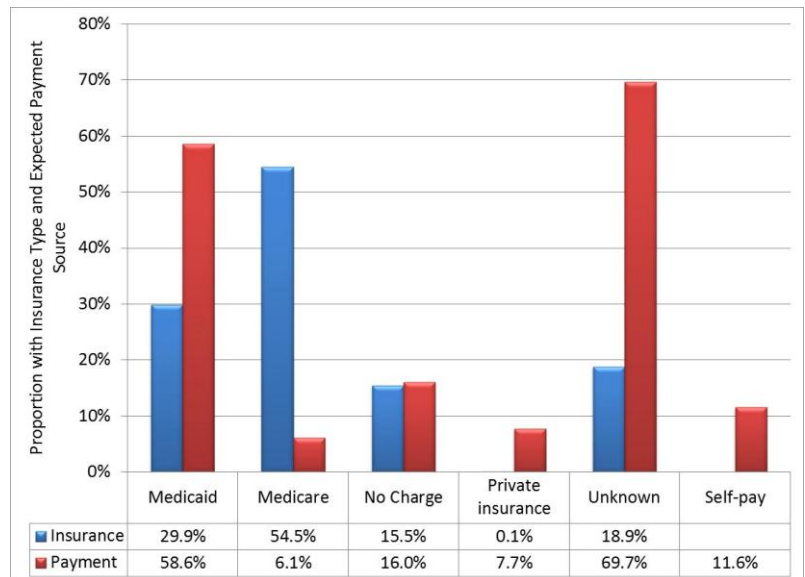
Alcohol was the most frequently used substance among older Washingtonians in publicly financed substance abuse treatment in 2008.\* Alcohol was mentioned as the primary substance of abuse in nearly 60 percent of admissions among those ages 50 and older. However, this was lower than both the national and regional rates. Alcohol was followed by cocaine at 22.5 percent, heroin at 14.7 percent, marijuana/hashish at 10.8 percent, opiates at 5.3 percent, and benzodiazepines/other tranquilizers at 2.4 percent.

\* The year 2008 is the most recent year for which treatment admission data regarding primary, secondary, or tertiary substance use by age group are available.

<sup>1</sup> TEDS data are collected by states that accept Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Guidelines suggest that states report all clients admitted to publicly financed treatment; however, states are inconsistent in applying the guidelines.

## TREATMENT ADMISSIONS AGES 50 AND OLDER—INSURANCE TYPE

Nearly 60 percent of older Washingtonians ages 50 and older who were admitted to substance abuse treatment in fiscal year 2008 were insured by Medicaid. However, Medicaid was the expected source of payment in only 30 percent of these admissions. More than 50 percent were covered by Medicare, but Medicare was the expected source of payment in only 6 percent. In nearly 70 percent of admissions, the source of payment was unknown, and in 16 percent the source was “no charge.” In these cases, the bills may have been directed toward the state’s SAPT Block Grant/state-funded treatment programs.

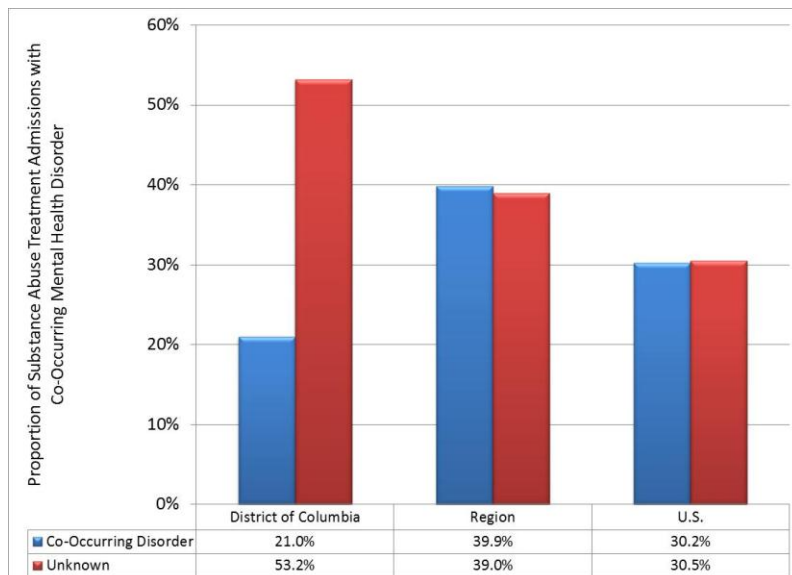


Source: TEDS, 2008

Data include only those individuals reported to TEDS

Please note: Totals do not sum to 100 percent because insurance/payment was calculated using the known type. The unknown category was calculated as a proportion of the total; 2008 is the most recent year for which data are available.

## TREATMENT ADMISSIONS AGES 50 AND OLDER WITH CO-OCCURRING MENTAL HEALTH DISORDERS



Source: TEDS, 2008

Includes only those clients reported to SAMHSA

Research shows a strong relationship between substance use and mental health disorders. Studies show 30–80 percent of people with a substance use or mental health disorder also have a co-occurring substance use/mental health disorder. The figure at left shows the proportion of older Washingtonians (ages 50 and older) admitted to substance abuse treatment who also had a mental health diagnosis. This rate appears lower than the national or regional rate. However, reporting practices influence these results and not all states in the region reported the existence of co-occurring disorders among respondents.

Please note: Totals do not sum to 100 percent because the unknown was calculated separately. Region does not include the U.S. Virgin Islands; 2008 is the last date for which data are available.

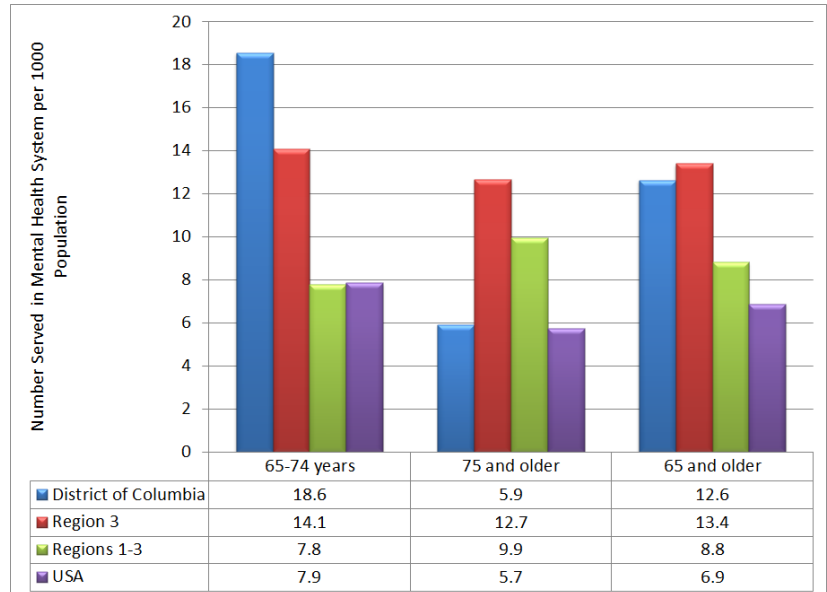


## Mental Health

### WASHINGTONIANS AGES 65 AND OLDER ADMITTED TO STATE MENTAL HEALTH SERVICES

Approximately 3.5 percent of the people who reported being served by the District's mental health system were ages 65 and older (2.7 percent were ages 65 to 74 and 0.76 percent were ages 75 and older). This represents a total of approximately 770 people. The figure at right shows the number of older District residents receiving mental health care per 1,000 population. The rate appears to be higher than the regional or national rates in the case of 65–74-year-olds but lower than the regional/national rates in the case of those 75 and older.

Please note: Regional data do not include Puerto Rico or the U.S. Virgin Islands.

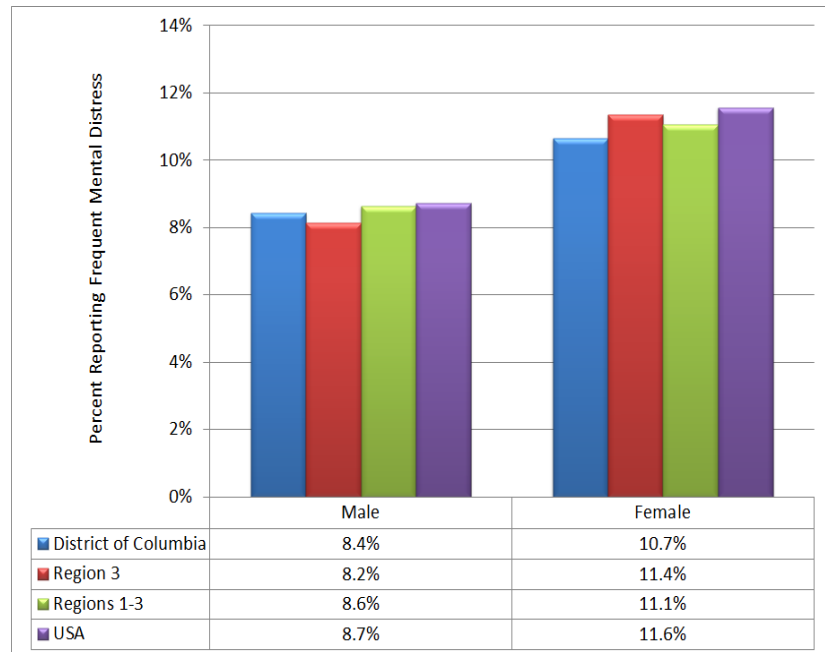


Source: Center for Mental Health Services (CMHS) Uniform Reporting System (URS), Federal Fiscal Year 2011

## WASHINGTONIANS AGES 50 AND OLDER REPORTING FREQUENT MENTAL DISTRESS—GENDER

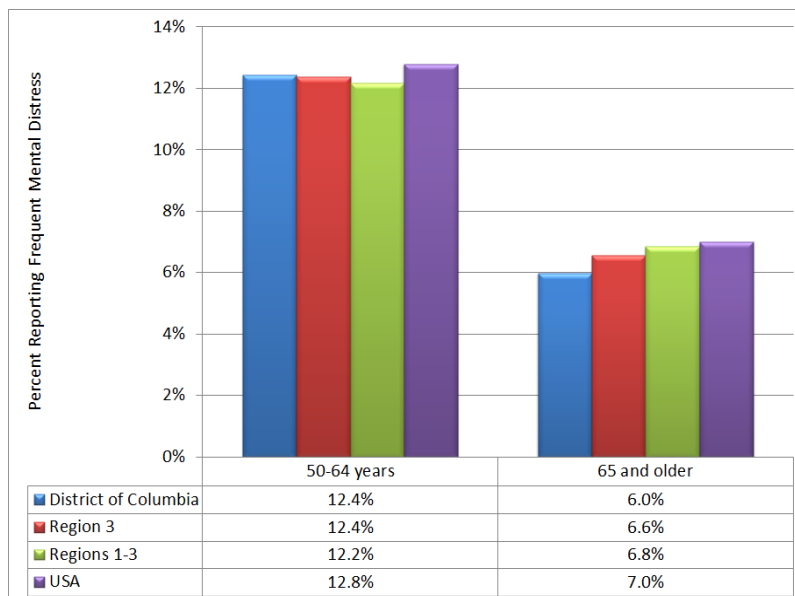
BRFSS, a household survey conducted in all states and several territories, asks the following question: “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” The CDC defines those individuals reporting 14 or more “Yes” days in response to this question as experiencing frequent mental distress (FMD). Nearly 11 percent of women ages 50 and older reported FMD whereas less than 9 percent of men did so.

Confidence intervals for regional/national and Washington estimates are less than  $\pm 2.0$  and  $\pm 0.2$  percent, respectively



Source: BRFSS, 2011

## WASHINGTONIANS REPORTING FREQUENT MENTAL DISTRESS—AGE GROUP



Source: BRFSS, 2011

Although older District men are more likely to binge drink, older women are more likely to report FMD. Nearly 9.7 percent of Washingtonians ages 50 and older report FMD: 12.4 percent of those in the 50–64 group and 6.0 percent of those in the 65 and older group.

Confidence intervals for regional/national and D.C. estimates for each group are less than  $\pm 0.2$  and  $\pm 2.0$ , respectively.

The table below provides a breakdown by age group and gender.

## Percentage of Washingtonians Reporting FMD by Age Group and Gender

	Male	Female
50-64 years	10.6%	13.9%
65 and older	5.2%	6.5%



## OTHER MEASURES OF MENTAL HEALTH

BRFSS collected other measures showing risk factors for mental and/or physical illness. These included:

- Social and Emotional Support (2010). BRFSS asked, “How often do you get the social and emotional support you need?” Responses included always, usually, sometimes, rarely, or never.
- Life Satisfaction (2010). BRFSS asked, “In general, how satisfied are you with your life?” Responses included very satisfied, satisfied, dissatisfied, or very dissatisfied.
- Current Depression (2006). In 2006, BRFSS included a special anxiety and depression module that collected data in 38 states and several jurisdictions, including the District of Columbia.
- Lifetime Diagnosis of Depression (2006). BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”
- Lifetime Diagnosis of Anxiety Disorder (2006). BRFSS asked, “Has a doctor or other healthcare provider EVER told you that you have an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic attacks, panic disorder, posttraumatic stress disorder, or social anxiety disorder)?”

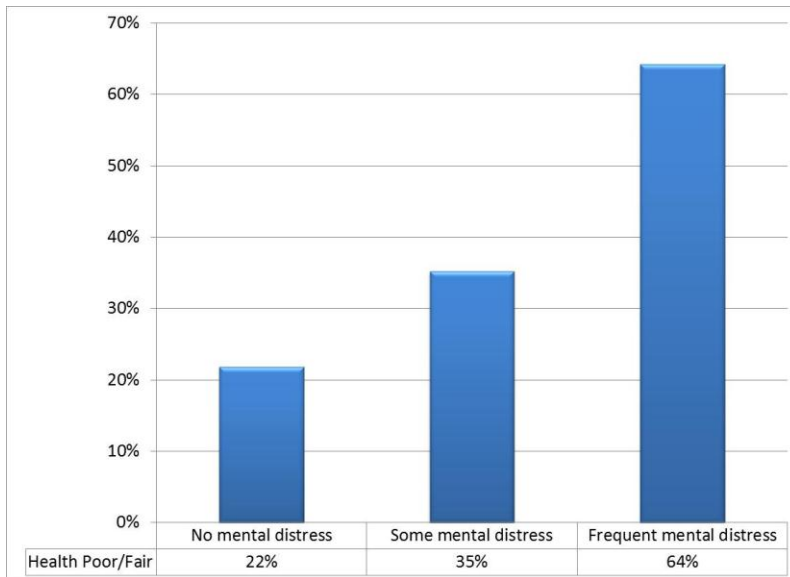
The results of these surveys among older Washingtonians are shown in the table below.

## BRFSS MEASURES

Age Group						
Indicator	Ages 50+		Ages 50–64		Ages 65+	
	Data %	Confidence Interval	Data %	Confidence Interval	Data %	Confidence Interval
Core BRFSS Indicators (2010)						
Rarely or never get social or emotional support	10.1	(8.9–11.3)	8.2	(6.7–9.7)	12.3	(10.4–14.2)
Very dissatisfied or dissatisfied with life	4.6	(3.8–5.4)	6.0	(4.7–7.3)	3.0	(2.0–4.0)
Anxiety and Depression Optional Module Indicators (2006) <sup>2</sup>						
Current Depression	5.4	(4.3–6.9)	6.3	(4.7–8.3)	4.2	(2.7–6.4)
Lifetime Diagnosis of Depression	15.0	(13.2–17.0)	18.7	(16.2–21.6)	9.9	(7.7–12.6)
Lifetime Diagnosis of Anxiety Disorder	9.6	(8.2–11.3)	11.7	(9.7–14.0)	6.9	(5.1–9.2)

<sup>2</sup> Data available at <http://apps.nccd.cdc.gov/MAHA/StateDetails.aspx?State=DC>.

### PEOPLE WITH FREQUENT MENTAL DISTRESS REPORT POOR PHYSICAL HEALTH



Older Americans who experienced FMD were more likely to report that their physical health was poor or fair (as opposed to good, very good, or excellent). As shown in the figure at left, although 22 percent of older Americans with no mental distress reported poor or fair physical health, more than 60 percent—nearly triple the rate—of those with FMD reported poor/fair health. Older Americans with FMD were also much more likely to report that they had experienced serious health problems.

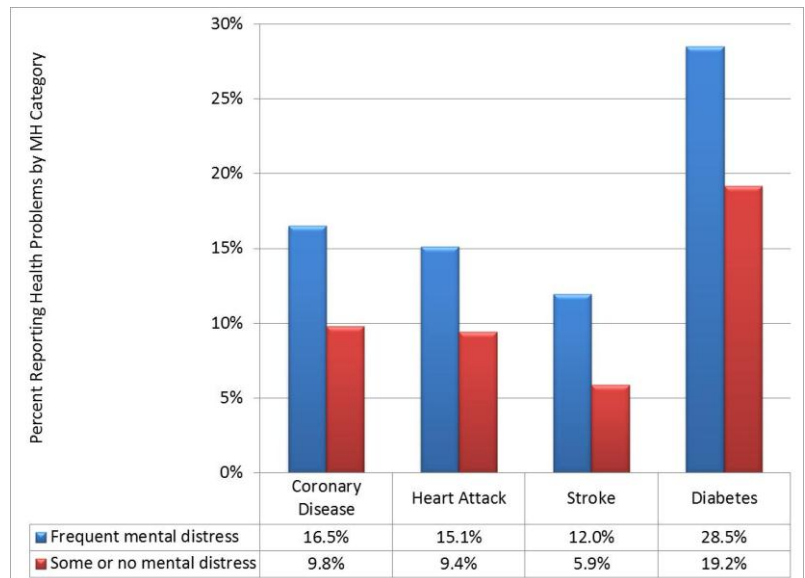
These differences are statistically significant.

Source: BRFSS, 2010

### RELATIONSHIP BETWEEN MENTAL DISTRESS AND SERIOUS HEALTH PROBLEMS

Older Americans who experience FMD, such as symptoms of depression or anxiety, are more likely to report that they had chronic health problems. People with FMD experienced strokes at twice the rate of those with some or no mental distress (12 percent versus 6 percent). They experienced coronary disease, heart attack, and diabetes/pre-diabetes at more than 1.5 times the rate of those with some or no mental distress (16.5 versus 9.8 percent for coronary disease, 15.1 versus 9.4 percent for heart attack, and 28.5 versus 19.2 percent for diabetes/pre-diabetes).

These differences are statistically significant.



Source: BRFSS, 2010

## DATA SOURCES

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (<http://www.cdc.gov/brfss/>), CDC. Atlanta, Georgia: U.S. Department of Health and Human Services, 2010 and 2011. BRFSS is “the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.” BRFSS data are collected by local jurisdictions and reported to the CDC.

NATIONAL SURVEY ON DRUG USE AND HEALTH (<https://nsduhweb.rti.org/>), Center for Behavioral Health Statistics and Quality. Rockville, Maryland: U.S. Department of Health and Human Services, SAMHSA ICPSR32722-v1; Ann Arbor, Michigan: Inter-university Consortium for Political and Social Research [distributor], 2011-12-05. doi:10.3886/ICPSR32722.v1. NSDUH, managed by SAMHSA, is “an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older.” NSDUH data are most frequently used by state planners to assess the need for substance abuse treatment. NSDUH data also include information about mental health needs.

NATIONAL VITAL STATISTICS (<http://www.cdc.gov/nchs/nvss.htm>), CDC. Atlanta, Georgia: U.S. Department of Health and Human Services, 2009. The CDC Web site describes the National Vital Statistics System as “the oldest and most successful example of inter-governmental data sharing in Public Health and the shared relationships, standards, and procedures form the mechanism by which NCHS [National Center for Health Statistics] collects and disseminates the Nation’s official vital statistics. These data are provided through contracts between NCHS and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events—births, deaths, marriages, divorces, and fetal deaths.”

TREATMENT EPISODE DATA SET (<http://www.icpsr.umich.edu/icpsrweb/SAMHDA/>), Center for Behavioral Health Statistics and Quality. Rockville, MD: U.S. Department of Health and Human Services, SAMHSA; Treatment Episode Data Set—Admissions (TEDS-A), 2010. ICPSR30462-v2; Ann Arbor, Michigan: Inter-university Consortium for Political and Social Research [distributor], 2012-07-18. doi:10.3886/ICPSR30462.v2. States that participate in the SAPT Block Grant submit individual client data to TEDS. TEDS includes both admission and discharge data sets, and some 1.5 million admissions are reported annually. TEDS includes information about utilization of substance abuse treatment services as well as client demographic and outcome information.

UNIFORM REPORTING SYSTEM (<http://www.samhsa.gov/dataoutcomes/urs/>), CMHS. Rockville, Maryland: U.S. Department of Health and Human Services, SAMHSA, 2011. States that receive CMHS Block Grants are required to report aggregate data to URS. URS reports information about utilization of mental health services as well as client demographic and outcome information.

U.S. CENSUS BUREAU (<http://www.census.gov/people/>). Two main sources of Census Bureau data were used in this report: (1) population estimates and (2) population projections. Population projections and estimates were created using 2010 Census data.

**This profile was developed by the Substance Abuse and Mental Health Services Administration in partnership with the U.S. Administration on Aging.**